



State of Maryland – Department of Health and Mental Hygiene  
**BEHAVIORAL HEALTH ADMINISTRATION**  
Catonsville, MD 21228

**PHYSICIAN'S OR PSYCHOLOGIST'S CERTIFICATE TO ACCOMPANY  
APPLICATION FOR INVOLUNTARY ADMISSION**

Involuntary admissions of individuals to facilities for the care or treatment of mental disorders are governed by Health General Article, §§10-613 – 10-617, Annotated Code of Maryland and COMAR 10.21.01.

An application for involuntary admission of an individual may be made by any person who has a legitimate interest in the welfare of the individual. The application must be on the required form (DHMH #34), be dated and signed by the applicant, state the applicant's relationship to the individual for whom involuntary admission is sought, and be accompanied by the certificates of two physicians or one physician and one psychologist.

A certificate for involuntary admission shall be on this form; be based on the personal examination of the physician or psychologist who signs the certificate; and include: (1) A diagnosis of the individual's mental disorder, (2) An opinion that the individual needs inpatient care or treatment, and (3) An opinion that hospitalization is needed for the protection of the individual or another. A certificate may not be used for admission if the examination was done more than 1 week before the certificate is signed or more than 30 days before the facility receives the application for admission.

A certificate shall have attached to it any available medical reports or records that support the individual's need for involuntary care or treatment in a facility, for the protection of the individual or others. If these reports or records are not readily available or do not exist, then one of the certifying physicians or psychologist shall submit a detailed note summarizing the medical history of the individual; stating the individual's current symptoms and diagnosis, and giving an explanation of why, in the certifying physician's or psychologist's professional judgment, the individual meets the requirements for involuntary care or treatment. (Health-General Article, §10-616 and COMAR 10.21.01).

If the individual is certified and there is not a bed available in the hospital affiliated with that Emergency Department (ED) then the ED staff should check with the bed registry through MIEMSS or call hospitals not on the registry to find a bed. For bed availability, please refer to the MIEMSS website at <http://www.miemss.org> then click on "Hospital Login (FRED)" to sign in.

The services and programs of the Department of Health and Mental Hygiene are provided on a non-discriminatory basis and in compliance with Title VI of the Civil Rights Act of 1964. Any complaints regarding alleged discrimination may be filed in writing with the Director, Behavioral Health Administration, Spring Grove Hospital Center, 55 Wade Avenue, Dix Building, Catonsville, MD 21228, and the Office of Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Philadelphia, PA 19106-3499.

## CERTIFICATION BY PHYSICIAN OR PSYCHOLOGIST

I, \_\_\_\_\_, of \_\_\_\_\_  
(Name of Physician or Psychologist) (Name of Facility or Office Address) (Telephone Number)

certify that on \_\_\_\_/\_\_\_\_/20\_\_\_\_, I personally examined:

Name of Individual: \_\_\_\_\_  
(Last) (First) (MI)

Address of Individual:

\_\_\_\_\_  
(Street) (City) (State) (County) (Telephone Number)

\_\_\_\_\_  
Birth Date Age Sex Marital Status SS#

Hispanic or Latino Origin: ☐ yes ☐ no

Race (check all applicable racial categories):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Name of Next of Kin: \_\_\_\_\_ Relationship to Individual: \_\_\_\_\_

Address \_\_\_\_\_  
(City, State, Zip) (Telephone Number)

THE DIAGNOSIS OF MENTAL DISORDER IS:

\_\_\_\_\_  
\_\_\_\_\_

SYMPTOMS:

\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS (type and dosage):

\_\_\_\_\_  
\_\_\_\_\_

EMERGENCY MEDICATIONS, IF ANY:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I find that:

- ☐ The individual has a mental disorder;
  - ☐ The individual needs inpatient care or treatment;
  - ☐ The individual presents a danger to the life or safety of the individual or of others;
  - ☐ The individual is unable or unwilling to be admitted voluntarily;
  - ☐ There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual; and
- ☐ If the individual is 65 years old or older and is being referred for admission to a State facility, geriatric evaluation team has determined that there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual.

- ☐ I am licensed under the Health Occupations Article, Title 14, Annotated Code of Maryland, to practice medicine in the State of Maryland.
- ☐ I certify that I am licensed under the Health Occupations Article, Title 18, Annotated Code of Maryland, to practice psychology in the State of Maryland.
- ☐ I do not have a financial interest, through ownership or compensation, in a proprietary facility to which admission is sought for the individual whose status is being certified.
- ☐ I am not related, by blood or marriage, to the individual or to the applicant for the admission of the individual.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Physician or Psychologist: \_\_\_\_\_